

noclor

RESEARCH SUPPORT

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Research Matters

NEWSLETTER

First thoughts...

A seriously worrying aspect of UK researchers' race to develop a safe and effective COVID-19 vaccine is the alarmingly low involvement of people from black and minority ethnic backgrounds in clinical trials.

Data from different communities and different people is needed to improve understanding of the vaccines through large-scale clinical trials.

Yet only 7% were from ethnic minorities – despite the evidence that they are disproportionately at higher risk of

“Mistrust within BAME communities is one indication of how health inequalities and lack of diversity impact on research”

– Lynis Lewis,
Service Director, Noclor
Research Support



complications if they catch the virus.

Sadly, mistrust within BAME communities is just one indication of the impact on research – from top to bottom – of the health inequalities and lack of diversity that we examine in this issue of the newsletter.

Ten years on from his “Fair Society, Healthy Lives” strategic report commissioned by the government, WHO expert **Professor Sir Michael Marmot** (page 3), former professor of epidemiology and public health at UCL, explains why our healthcare system is not to blame for the unacceptable health inequalities in the UK.

It is a sad reflection of our society that many people from BAME communities still access mental health treatment services only via hospital A&E departments or the police.

Steve Pilling (page 6), UCL Professor of Clinical Psychology and Clinical Effectiveness, describes the increasing efforts being made to reverse these disturbing statistics.

Emmanuel Rollings-Kamara (page 8), head of research operations based at Noclor HQ, talks about the positive impact that joining an ethnically diverse workforce had on the development of his career.

Four black female researchers (page 10) based in London set out the steps that urgently need to be taken on equality, diversity and inclusion in all areas of research – including in the ivory towers of academia.

Finally, **Dr Vanessa Apea**, sexual health and HIV consultant physician at Barts Health NHS Trust, explains how her key aim as BAME clinical champion is to highlight the importance of helping to create and develop role models.

● Visit our website www.noclor.nhs.uk or follow us on Twitter [@NoclorResearch](https://twitter.com/NoclorResearch) for more news and details on how we support the vital research work carried out by our partner trusts.

We also welcome your feedback, as well as any suggestions for topics to be covered in future issues of the newsletter.

NHS is still our greatest hope for health equality

Prof Sir Michael Marmot, chair of the WHO Commission on Social Determinants of Health, on research that shows why the main causes of unfairly higher levels of poor health lie outside our healthcare system

As long ago as 1978, I published my first paper on health inequalities. Forty-two years later, I'm still concerned with the same issue. Initially, my concern was with describing the issue; then it was with understanding how health inequalities arose; now, much more, it is with what we can do to reduced health inequalities.

Since 1985 I have been Professor of Epidemiology and Public Health at UCL; and, over the last 15 years, I have been working

with the World Health Organisation to foster action on social determinants of health, based on the global evidence. I am delighted to see that what I was once doing as a rather obscure research activity all those years ago is being taught to students around the world. It's great that it's widely recognised, but we still need more action.

When we talk about health inequalities, we mean the systematic differences in health between socio-economic groups. Various ratios of socio-economic position will predict ill health: people living in more deprived areas, and people with fewer years of education and low personal income, have worse health.

In my 2010 strategic review for the government – Fair Society, Healthy Lives [<https://bit.ly/3jqm2c6>] – we took as read that universal health coverage is of vital importance.

While the NHS may not be perfect at guaranteeing universal access, the

evidence shows that it works better in respect of equity than the healthcare system in any other country. This means that the causes of inequality lie outside the healthcare system.

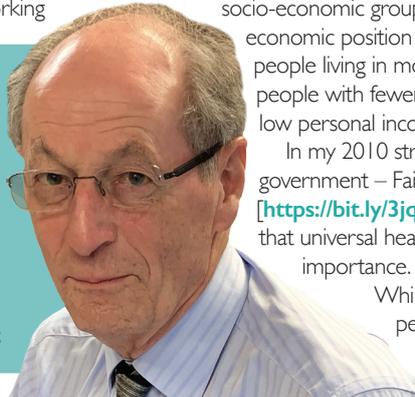
In the 2010 Marmot Review, we summarised the causes in six domains: early child development; education and lifelong learning; employment and working conditions; having at least the minimum income necessary for a healthy life; healthy and sustainable communities in which to live and work; and a social determinants approach to prevention, recognising the importance of the 'causes of the causes' – the social determinants of behaviours related to such aspects as diet, smoking, drinking, exercise.

Since the Health and Social Care Act of 2012, when public health was moved into local government, the government has reduced funding for public health by something like £800 million; and has reduced the budget of Public Health England by around 40%.

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“The impact of the virus on marginalised communities was predictable in exposing inequalities in society and amplifying them”

– Prof Sir Michael Marmot



Making research everybody's business

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It is much harder, therefore, for public health professionals to do their jobs if their funding is being drastically reduced, particularly for those in local government who work across the various domains.

It's not just poor people who have poor health, it's a gradient: the more deprived, the worse the health. If the gradient follows social hierarchies – all complex societies have social hierarchies based on such things as education, income, living conditions – it is probably inevitable that there will be health inequalities.

However, there are two types of evidence that should make us optimistic – and the first is that the magnitude of health inequalities varies among countries.

In my 2015 book, *The Health Gap* [<https://bit.ly/3oy0kqgm>], I published a comparison of life expectancy at age 25 by years of education. In Sweden and Norway, the gap between those with a small amount of education and those with tertiary education is quite small, whereas in Estonia, Bulgaria, Romania, Poland and Hungary it is quite big.

This means that although it may be an inevitable feature of society that there will be a gradient, the magnitude of it varies.



The second piece of evidence is that health inequalities vary over time within society. In my report published in February this year, *Health Equity in England: The Marmot Review 10 Years On* [<https://bit.ly/2TjserC>], we showed that the inequalities had increased over the last decade. But they can also decrease.

The thrust of the 2020 report was that we were not in a good state in Britain with respect to health. Life expectancy had stopped improving, inequalities were getting worse, and health for women in the poorest areas outside London was getting worse. So we should not want to go back to the status quo, and healthcare workers should

be active in arguing for something better.

With COVID-19, the social gradient in mortality has looked pretty similar to the social gradient in mortality from all causes, suggesting a common set of causes for inequalities in COVID cases and inequalities more generally.

However, in those with the highest levels of deprivation, the excess mortality from COVID was larger than the excess mortality from all causes. That is plausibly related to employment in frontline occupations, occupational exposure to virus, and living in multi-generational, overcrowded households.

There's been a lot of concern – and rightly so – that if you're overweight, or you've got diabetes, chronic obstructive pulmonary disease, asthma and the like, that you're at increased risk of mortality from COVID. But, by and large, that doesn't seem to be the reason for the excess in BAME groups.

The Office for National Statistics recently published findings [<https://bit.ly/34qveZJ>] on the excess mortality among BAME groups, showing that most of the excess can be attributed to deprivation or geography and not, interestingly, to prior health conditions.

The purpose of the initial lockdown should have been to put in place an effective test, trace

and isolate system. If we had done this from the beginning, our situation might now look like that in South Korea or Taiwan or Germany.

Some of the millions of pounds that has been spent on private companies and corporations that are not able to deliver on test and trace should instead have been spent on the NHS and public health – any number of volunteers had signed up to help with the contact-tracing activities.

But it was messed up, and instead of reaping the benefit of the lockdown in the spring, we squandered it. So now we're in this dreadful situation all over again.

Despite this, I'm hopeful that lessons will be learned. The question is: who learns? Those of us who look at the evidence will learn; the people who ignore the evidence may not.

If they mean what they say when they say they're following the science, then I become more hopeful that they will learn.

The impact of the virus on marginalised communities was predictable, unfortunately. I said very early on that the pandemic would expose the underlying inequalities in society and amplify them.

It shows just how important our understanding, analysis and need for action is on underlying inequalities in health.

UK HOLDS ITS HEAD HIGH IN VIRUS RESEARCH EFFORTS

Fierce criticism of the government's handling of the COVID-19 crisis contrasts starkly with widespread praise for the UK research community's efforts to find a solution to the pandemic.

A new UCLH vaccine research centre began two clinical trials in December to test an antibody combination that is believed may offer immediate and long-term protection against developing COVID-19 for people exposed to the new SARS-COV-2 strain of the virus.

And a vaccine developed by the University of Oxford/AstraZeneca has been a front-runner in the search for the holy grail of protection against the virus.

Trials in the UK on the effectiveness of the cheaply-available steroid dexamethasone in reducing death in COVID-19 cases have also led to it now being an affordable part of treatment regimens around the world.



Making research everybody's business

Cultural awareness will unblock pathways into care

Steve Pilling, UCL Professor of Clinical Psychology and Clinical Effectiveness, on increasing efforts to reverse disturbing statistics that many BAME people still access mental health treatment services via A&E or the police

We have known for a long time that people from a range of BAME populations have less than optimal access to mental healthcare, and that when they do get into care their outcomes are less good.

Work done by Robin Murray, Craig Morgan and colleagues at King's College London [<https://bit.ly/3hnlhkm>] found that people from black African and black Caribbean communities seeking treatment were more likely to arrive via the emergency departments or the police.

That probably means that the person has had a longer period of being unwell and, therefore, getting better will be more difficult.

Today, we still face the problem of how people from BAME populations get into treatment. Work we've done at UCL has shown that there is an over-representation of BAME people in emergency admissions.

We are still dealing with the same problem that Murray and colleagues have been reporting for more than 20 years. The question is, what do we do about it?

Services have tried to get BAME people into care more quickly, but cuts on the NHS and social care have impacted negatively on this work, and we've retreated a bit as a consequence.

One of my PhD students, Laura-Louise Arundell, has looked at whether you get better outcomes when you adapt psychological

interventions for BAME communities.

What has emerged from her work is that the use of same-language therapists, culturally-adapted treatments and an awareness of different cultural views of the nature of mental disorder all help.

However, the one adaptation that may be the most promising is getting the pathways into care right. This means outreach, linking with communities and referrers, and getting people into treatment quicker – structural things we can do something about. It's a positive message in a way because it's a relatively simple, practical thing to do.

But what about people from BAME populations who work in clinical services? Stephani Hatch, Professor of Sociology and Epidemiology at King's College London's Institute of Psychiatry, Psychology & Neuroscience, has a Wellcome Trust grant for the TIDES study (Tackling Inequalities and Discrimination Experiences in Health Services).

“How might your own attitudes and biases impact on the treatment choices for people from BAME communities?”

– Prof Steve Pilling





This study is looking at how staff attitudes and beliefs may impact negatively or positively on the care a person gets.

For example, as a clinician in an outpatient clinic or an emergency department, what is

your response to a young black man or young Asian women who comes in for treatment?

How might your own attitudes and biases impact on the treatment choices for people from BAME communities?

In terms of getting people from BAME communities into the profession, from a clinical psychology or a psychologist therapy perspective, we are trying, but could do better.

At the moment, about 40% of the trainees on the Psychological Wellbeing Practitioner (PWP) programme we run at UCL are from BAME communities. And as PWPs form the bulk of people going to train as High Intensity Therapists, we should start to see real change in the number of people from BAME communities working as psychological therapists in services such as Improving Access to Psychological Therapies (IAPT).

In clinical and educational psychology programmes at UCL, the position has not been that great – with better representation from Asian communities, but lower from black Caribbean and black African communities.

Ten years ago, about 10% of qualified clinical psychologists were from BAME communities, and this was reflected in the percentage of trainees on courses at the time.

My colleagues at UCL – in particular, Dr Kat Alcock, a senior clinical tutor – are addressing this issue, starting with the selection process. We have shifted the position from that in 2009,

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Making research everybody's business

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when only 9% of successful applicants were from BAME communities, to 24% in 2019. But we need to do more.

We need to be reaching out to undergraduate courses, and beyond that to schools. If you look at the UCL psychology undergraduate course, which is very competitive, 40% of students are from BAME communities, but many are international students from China and south Asia.

We've still got a real challenge in terms of engaging young people from BAME communities in the UK, which is currently at about 12% of undergraduate programmes. Numbers have improved, but we need to build on the work that Kat and colleagues are doing – and that means reaching out to schools and getting more people from BAME communities to apply.

There's a real push now to mentor and bring people through. We had a bright young researcher of Filipino descent who was reluctant to apply to do clinical psychology because she saw the profession as dominated by white, middle-class women. It was only with a lot of encouragement that she eventually decided to put in an application.

Image: Stefano Pollio on Unsplash



In my research group, 50% of the PhD students are from BAME communities. UCL has been sponsoring a PhD studentship for BAME communities for the last two years, and in my division, Psychology and Language Sciences, the faculty has funded the creation of a combined practical work/teaching PhD for a BAME student.

This is about providing people with opportunities – getting into research posts

that allow them to move on to a research career. However, we still have a long way to go as there are only 12 black professors of psychology in the country, and that's just not good enough.

John Roiser, together with fellow UCL professors Pasco Fearon and Claudia Cooper, recently led a successful bid for funding from the Wellcome Trust for a four-year PhD programme in mental health science – the first of its kind. It started in September and will fund six new students a year for the next five years.

John, Pasco and Claudia have gone out of their way to make sure that we take the issue of access for BAME students seriously, and the selection of people on that programme shows that they have done a very good job.

It's not an all-white Oxbridge group of research students, which might be expected as the "typical" profile for a highly-competitive UCL course, but a great mix of people from different BAME communities and different universities.

This is just the sort of prestigious programme that helps people get on the research ladder. It's a real attempt to deal with the issue.

Familiarity breeds content in career options

I feel very fortunate to work as head of research operations at Noclor because not only do we have a very diverse workforce, we also have diversity at all levels.

When people come into our office they are often surprised that there are black people in senior posts. Even if a workforce is diverse, black people are normally concentrated in the lower NHS bands. It's almost like a glass ceiling.

There's no pressure on us at Noclor to think, "Oh, we have to hire a black person, or a white person", because there is already such a mix here.

"Seeing other black people around, and in authority, made me feel more relaxed and free"

– Emmanuel Rollings-Kamara



It begs the question: if this can happen organically, but isn't mimicked in other services, does it mean that the recruitment process in those areas is being influenced?

The reason I left my only previous job, as a development scientist in a pharmaceutical company, was because they were relocating and I didn't want to do the commute.

When a job as research governance officer at Noclor came up, I initially saw it as a stopgap, but I stayed because I immediately saw that it was an organisation that might give me the chance to rise up the ladder.

While I wouldn't say I ever experienced overt racism in the workplace, I never felt confident in meetings. I was concerned about how I would be viewed if I were to speak up – whether people would think I was acting above my station.

Being in a minority can affect how you act, even if nothing is said. You're always second-guessing what people think of you. Everybody feels self-conscious to some extent, but the racial dimension can be overlooked.

I noticed straight away at Noclor how the new environment gave me the opportunity to express myself and to develop my confidence. Seeing other black people around, and black people in authority, made me feel more relaxed and free.

Through my work, I am very aware of the problem of people from BAME groups not wanting to participate in research studies. There's a general distrust of the system that stems from information conveyed from one generation to the next.

If you've been exposed to a general distrust of the system, authority, etc for most of your life, it becomes ingrained and can manifest as a reluctance to engage. But if a black person was asked to join a research study by another black person, then they might be more open to it.

With BAME groups being disproportionately affected by COVID-19, there are conspiracy theories about us being "targeted". But even for those who believe it is a natural pandemic, there is a view that we are seen as not that important, and so not much attention is being focused on our wellbeing.

Making research everybody's business

Academia must open doors and minds to black lives

The 'tired mantra' that ethnic minorities are hard-to-reach is challenged in a powerful UCL blogpost advocating the integration of equality, diversity and inclusion into all areas of research activities

A group of four black researchers in London has collaborated in setting out a series of urgently-needed steps to recognise ethnic fluidity and diversity, and how to make research more accessible to different black communities.

Cherelle Augustine, Fola Afolabi, Melvina Woode Owusu and Mable Nakubulwa are all

black female researchers, but the significant differences in how they self-identify ethnically illustrates the dynamic nature of ethnicity and the importance of understanding this in academic and research endeavours.

They explore these subtle, varying reflections on self-identity and ethnicity in a forward-looking

blogpost on Black Inclusion in Research for the UCL Centre for Co-production [<https://bit.ly/35dEQWF>].

Because of the complexities of unpicking the meaningfulness of race, ethnic categorisations and their use in research, they narrowed their focus on how to address the lack of

Cherelle Augustine

Engagement Co-ordinator at NIHR Applied Research Collaboration North West London. She and her parents were born in the UK, and her grandparents were born in Dominica. She identifies as Black British of Caribbean descent and has strong ties to her cultural roots, with both cultures influencing her ways of thinking.



Fola Afolabi

Graduate management trainee at Imperial College London. She was born in Nigeria and often describes herself as Nigerian. It was not until she became a British citizen that she began sometimes to refer to herself as Black British because of an awareness of the privileges one has in certain spaces through identifying with Britishness.



representation of black people in academia. They asked three key questions:

1. If ethnicity is so fluid, how can researchers identify people from specific ethnic groups?
2. How can we move forward from the tired mantra of ethnic minorities being “hard-to-reach”?
3. What can we do (now!) to promote meaningful equality, diversity and inclusion in research?

Whether seeking to engage black people in research as informants, participants, public contributors, research champions or

co-producers, the researchers stress the need to move beyond the broad terms of “BAME – black and minority ethnic” or “ethnic minorities”.

On the first point, they argue that discussing under-representation at a granular level through referring to specific communities – such as Trinidadian or Jamaican – can help us to account for the diversity of ethnic groups when engaging them.

For example, a young black person whose grandparents arrived in the UK as part of the Windrush generation may not respond

to a notice targeted at “Black Caribbeans”.

It is therefore necessary, when thinking about engaging black people in research, to recognise that Black Africans, Black Caribbeans and Black Britons do not come from a single “black community”.

On the contentious issue of entire ethnic groups being regarded as hard-to-reach, they flip the question and ask whether it is in fact academia that is hard-to-reach.

In the UK’s largest cities, different ethnic groups often live in pockets, alongside one

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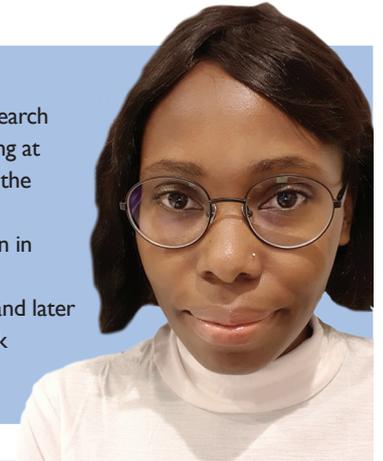
Dr Melvina Woode Owusu

Research Programme Manager at University College London. She was born in the UK to parents who migrated from Sierra Leone, fully embraces her identity as a UK-born African and as Black British, and reports her ethnicity as both Black African and Black British – depending on her mood and who is asking.



Dr Mable Nakubulwa

Chartered psychologist, is a Research Associate and Statistician working at Imperial College London within the Public Health and Information Intelligence Theme. She was born in Uganda, but then moved first to Sweden, where her family lives, and later to the UK. She identifies as Black African of Ugandan descent.



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another, meaning that communities are actually quite visible and not at all hard-to-reach. For example, Caribbean people of all cultures, ages and generations can easily be found in the London borough of Lambeth, while Somalis are clearly an emerging community in Camden.

The researchers argue that academia, rather than just looking outwards from research, needs to look inwards as “it is designed in a way that makes itself inaccessible to people who are different from those sitting in the ivory towers”.

They point out that black students are more likely to face adversity on a systematic level, with National Union of Students data showing that they often enter further and higher education without the same level of academic and study skills as white counterparts.

They then face further challenges in accessing funding for research due to various prerequisites, including an emphasis on prior attainment.

“Black students are under-represented in the more prestigious academic institutions and are less likely to attain an upper-second-class or first-class honours degrees compared with their white counterparts,” the researchers say.

“Even when under-represented groups gain

employment in ivory towers, they are subjected to systemic racism that impacts on their confidence, opportunities and power to engage.

“When research is conducted, is it therefore surprising that research teams are mostly white and from higher socio-economic backgrounds?”

With pressure from the Black Lives Matter movement and the higher education regulator, the Office for Students, there are now significant and long overdue drives to improve representation.

It is designed in a way that makes itself inaccessible to people who are different from those sitting in the ivory towers

However, the UCL bloggers say the sector “needs to be proactive in its approach towards inclusion – instead of only focusing on diversity – by honestly considering its entire approach to improving representation.

“That means from lecture content to recruitment of research teams (not solely “back office” staff), and the involvement of members of the public and/or those with lived experiences in research, from design to dissemination.”

So what can be done immediately to promote systematic and measurably meaningful – rather than tokenistic – equality, diversity and inclusion in research? They suggest the following actions:

- Support access and outreach initiatives within higher education institutions to improve the recruitment and educational attainment of black students.
- Make the essential criteria included in job descriptions more inclusive, so that they do not exclude those who have taken non-traditional paths or who have not had, or felt able to take, specific opportunities.
- Diversify recruitment panels, to increase diversity of thought and send a message to job candidates, that “you belong here, too”.
- Reflect on and question (un)conscious biases and preferences during the recruitment process.
- Provide mentorship opportunities to all members of research teams, to support career progression – including, for example, administrative staff who may quietly aspire to become more involved in research.
- Embed the principles of equality, diversity and inclusion in research from the outset, and build in review points to ensure the co-production or involvement work remains authentic.



- Provide opportunities for everyone to offer fresh perspectives on research.
- Where members of the public share their knowledge and lived experiences, remunerate their contributions and facilitate this by including appropriate costings in applications at the bid stage.
- Register for alerts with funding bodies, to finance ongoing and responsive involvement and equality, diversity and inclusion initiatives.

The researchers conclude by saying: "While we cannot change a centuries-old system in a blogpost, we hope to have highlighted how the use of terms such as 'hard-to-reach', 'ethnic minorities' and 'BAME' can worsen marginalisation and systematic oppression.

"It is therefore important that black people have equal access to key positions at all levels of research, including senior management, in order to prevent continued exclusion.

"Perhaps if we integrate the principles of equality, diversity and inclusion into all our research activities – from education, employment and recruitment through to research and dissemination – it will counter the idea of entire communities being 'hard-to-reach' and hail them as indispensable co-producers and leaders within research."

Making research everybody's business

East winds of change can break down stereotypes

Dr Vanessa Apea, sexual health and HIV consultant physician at Barts Health NHS Trust, explains how negative reactions to her ethnicity have made her all the more determined to champion BAME role models

The collision of this pandemic and Black Lives Matter has really made me reflect on my personal journey – and what’s come out most is how little space there is for us to talk about our experiences related to race.

The other important conclusion is just how little representation there is in terms of role-modelling for black and minority ethnic (BAME) people.

I’ve had patients who don’t want to see me because I’m black. I’ve also been told I’ve done well “for my kind”, and people make

assumptions and think I’m the secretary. It’s actually been harder as I’ve become more senior.

I find this incredibly disappointing, but I’ve worked extremely hard to get where I am and I enjoy what I do, so for the most part it doesn’t deter me.

I was lucky because I had opportunity. I went to a grammar school and was told that I could do whatever I wanted to do. And I’ve had many allies along my career journey and in my personal life.

I was born and brought up in the UK, but my family are originally from Ghana, and have always been my cheerleaders in the background. My community was also incredibly important, and what I recognise more and more is that a lot of people don’t have that.

The way to improve things is by using what you have to help others, and I try to do this by mentoring people from BAME and other socially-disadvantaged groups in my role as clinical lead for sexual health

and co-lead BAME clinical champion for NIHR North Thames.

I was co-lead author on a report [<https://bit.ly/2TkjgdI>], published in June, about COVID-19 hospital admissions to five acute NHS hospitals in east London, across Barts health trust.

It is one of the largest specific hospital cohort studies, and it was pivotal because more than 60% of our participants were from a BAME background.

We analysed the data of 1,737 patients, looking at the outcomes and stratifying them by ethnicity according to how it was recorded – that is, white, black, Asian and other:

What we saw was that patients of black or Asian background had increased likelihood of death from COVID-19 by 30 days, which concurred with what we were seeing in national data. It was important to identify that within east London so that we could respond to it.

Another key point was that the white patients who were dying were older and frailer than the

“We need to make sure communities are at the centre of the response, which hasn’t always been the case”

– Dr Vanessa Apea



BAME patients who were dying. The average age was around 73 for white patients, about 59 for Asian patients, and about 64 for black patients.

We looked at factors that could account for this – co-morbidity, deprivation, frailty, and various diseases such as kidney disease and heart disease – but they didn't fully explain the difference.

People often think of race and ethnicity as biological or genetic constructs, but they're actually social constructs.

What we need to understand better are the social determinants of health. BAME people are more likely to live in deprived areas and in multi-generational households, and to do jobs that expose them to higher risk.

There's a certain privilege linked to prevention: to socially distance and stay at home, you have to have somewhere to stay; you have to have electricity, and you have to have access to wifi to work from home. Then there's also the question of whether the messaging got out to all communities for people to socially distance.

The next part of our analysis work is qualitative. We've been fortunate to get seed



funding from Barts Charity to work with local communities to develop interventions that deal with the impact of COVID-19. We'll be asking them what they think needs to be prioritised in local and national responses. We need to make sure communities are at the centre of the response, which hasn't always been the case.

As part of my BAME clinical champion role, I make sure that we have representation within vaccine research, and a lot of my work has been about the messaging. Many marginalised groups, particularly black communities, have been the victims of unethical medical research, and that experience has generated a lot of mistrust.

We need to acknowledge that concern, then

reassure communities that things have changed significantly. It's about explaining that we have been disproportionately affected and we want to make sure that the treatment and prevention is relevant to us – and that the only way that that can happen is if we participate in studies.

Vaccine research involves complicated information that is forever changing, so we've been looking at different ways of communicating it. I'm part of a fantastic working group that has come up with the idea of making an animation. We're also doing talking-heads videos that can be shared.

There's now a collective acknowledgment of the disproportionate effect of COVID-19 on BAME people, so we need to push this agenda forward. But I am mindful that it must not be tokenistic, and that these conversations and actions continue.

In the next couple of months, we want to see direct intervention as a result of what we know already, and then ongoing research to understand more and evaluate more. Often, people wait for the research and then do an intervention, but I think we need to be proactive, and to do it together.

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RESEARCH SUPPORT

Projects currently recruiting

● **PRINCIPLE:** This nationwide Urgent Public Health study is asking all GPs to direct potential participants aged 50 and over with symptoms of COVID-19 to self-screen via the website www.principletrial.org. The trial team may contact GP practices to ask for information confirming eligibility of people who consent to participate. noclor.norththamescrn@nhs.net

● **PATHFINDER:** The Problem Adaptation Therapy (PATH) for Depression in Dementia study investigates whether an adapted form of this problem-solving therapy has been helpful in the very early stages of dementia, and whether it can be successfully applied in an NHS setting. Phase 1 will develop a PATH manual that can be used by carers, under the supervision and guidance of NHS staff, and phase 2 is a randomised clinical trial. contact.noclor@nhs.net

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Editorial content:
Katie Shimmon & David Clare

This paper is Forest Stewardship Council certified

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